OGDENCLINIC
CANCER CENTER

PATIENT FORMS

Utah Hematology Oncology
OGDENCLINIC

Carl R. Gray, MD

Jan W. Davis, ANP-C Lynn C. Larsen, NP-C Kelly D Mikesell, PA-C Kylie Money, PA-C

Dear Patient,

Welcome to Utah Hematology Oncology. We will make every effort to help you face the challenges of your condition. In order to do this, we need some information from you.

Please fill out the attached forms as completely as possible and bring them with you to your first visit. Make sure to bring a current medication list that also includes all over-the-counter medications and supplements, along with doses and how often you take them. On the medical review form, please note any symptoms you are currently having. There is also an area to note when you have had a colonoscopy and other critical screening tests.

If you have an email address, please provide it where indicated so that we can invite you to have access to our portal. This will allow you to view a great deal of your information including visit notes, lab results, educational materials tailored to your condition and medications, and much more. If you do not have an email address, but one of your medical contacts does (spouse, child, etc), you may give us their email if you feel comfortable doing so to use for this purpose. We can also assist you in setting up your own free email account.

If you have questions, feel free to call us at 801-476-1777. We look forward to serving you.

5290 South 400 East
Ogden, UT 84403
801.476.1777 (phone)
801.479.1479 (fax)

2132 North 1700 West #301
Layton, UT 84041
801.476.1777 (phone)
801.479.1479 (fax)

MEDICAL HISTORY FORM

Name _____
DOB _____
Age _____
Today's Date _____
Reason For Referral _____
Referring Provider _____
Primary Care Provider _____
_____
Occupation_____

Medications – Please list any prescriptions or non-prescription medications you take each day
_____
_____
_____
_____
_____
_____
_____
_____

Allergies – List any known drug allergies or contrast material such as iodine
_____
_____
_____
_____
_____
_____

Medical Conditions – Diabetes, Hypertensions, Heart Disease, Lung Disease or Liver Problems, any Previous Cancer?
_____
_____
_____
_____
_____
_____

Past Surgeries – Please list all surgical procedures you have had performed and the approximate year you had the surgery_____
_____
_____
_____
_____
_____
_____
_____
Colonoscopy (Dates)_____
_____

Obstetrical History (Female Patients)

Last Menstrual Period _____
Age of 1st Pregnancy _____
Number of Pregnancies _____
Have you had a miscarriage?_____
If yes, how many?_____
Date(s) of miscarriage_____
Have you ever used any hormonal supplements such as Estrogen or Premarin? Yes or No
If yes, how many years? _____
When did you stop? _____

Family Medical History

Please list any significant medical problems such as cancer or blood disease with your family?
Mother (Alive/Deceased) _____
Father (Alive/ Deceased) _____
Brothers _____
Sisters _____
Other (Specify) _____
Marital Status _____
Number of Children (If any) _____
Do you currently drink alcohol? _____
If yes, how much per week?_____
If no, when did you quit? _____
Do you currently smoke? _____
If yes, how many per day? _____
If no, when did you quit?_____

PATIENT REGISTRATION FORM

Patient Name		Date
Address		
Home Phone	Cell Phone	
Employer	Employer Phone Number	
SSN	DOB	
Race	Gender	Language
Spouse Name	Spouse DOB	
Spouse Employer	Spouse Work Number	Spouse SSN
Referring Provider	NPI	
Referring Provider Phone Number	Diagnosis	
Primary Insurance	Policy Holder	
Member ID/Policy Number	Group Number	
Copay	Deductible	Max OOP

Patient Signature	Date
Employee	Date

Utah Hematology Oncology
OGDENCLINIC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please list any and all persons to whom your Protected Health Information may be released. It is not necessary to list physicians or other providers involved in your care. You may list anyone you feel would need to have information about your condition. **IF SOMEONE NOT ON THIS LIST REQUESTS INFORMATION, WE WILL NOT BE ABLE TO PROVIDE IT, EVEN IF THEY ARE RELATED TO YOU.** You may add or delete individuals from this list at any time.

I hereby authorize Utah Hematology Oncology PC representatives to release my Protected Health Information to the persons listed below. I understand that they may also be used as emergency contacts.

Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?
Name	Relationship	Phone	Emergency?

Patient Signature	Date
Reviewed by	Date
Entered into Centricity	Date

Utah Hematology Oncology
OGDENCLINIC

AUTHORIZATION FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION VIA ELECTRONIC MAIL

(Optional)

I hereby authorize Utah Hematology Oncology (UHO) to convey to me protected health information (PHI) and other communication via electronic mail (email), subject to the limitations of UHO's billing, electronic health record (EHR/EMR) and other systems. This may include statements, appointment reminders, test results, message responses, etc. I accept any and all responsibility for safeguarding that information once sent to the email address(es) indicated below. I further acknowledge that, in doing so, individuals not included on the list of persons to whom I have authorized UHO to release my PHI may therefore have access to that information. I further acknowledge that release of said information is at the sole discretion of UHO.

_____

Patient/Personal Representative Name (please print)

_____

Patient/Personal Representative Signature Date

_____

Preferred email address(es)

(Please complete this page and return to the receptionist)

_____

Received and entered Date

Utah Hematology Oncology
OGDENCLINIC

PATIENT FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to building a successful physician-patient relationship. Please understand that payment for services and therapy is part of that relationship. The following is a statement of our Financial Policy that we require you to read and sign prior to treatment.

PATIENT INFORMATION

A fully completed, current patient registration will be on file in your chart. A signature by the responsible party is required. IF THERE IS A CHANGE OF RESIDENCE, CONTACT INFORMATION, OR INSURANCE COVERAGE, IT IS YOUR
RESPONSIBILITY TO NOTIFY US OF THE CHANGE. You will be responsible for any claims denied because we do not have the appropriate information.

INSURANCE CLAIMS

PRIMARY INSURANCE: Utah Hematology Oncology PC (UHO) will file claims with your insurance upon your submission of proof of coverage (i.e., insurance card). In the event that you have insurance coverage, but cannot provide proof of coverage, payment is due at the time of service.

SECONDARY INSURANCE: Claims will be filed with secondary insurance if proof of coverage is provided at the time of service. However, if payment is not received in our office within 45 days of filing with the secondary payer, the balance will be transferred to your responsibility.
While filing insurance claims is a courtesy that we extend to our patients, all fees for services and treatments are your responsibility.

PATIENT FINANCIAL RESPONSIBILITY

THE PATIENT AND/OR PATIENT'S ESTATE IS RESPONSIBLE FOR ALL FEES. INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT. PREAUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. IF CLAIMS SUBMITTED BY OUR OFFICE ARE DENIED AFTER REASONABLE EFFORTS HAVE BEEN MADE BY UHO TO COLLECT PAYMENT FROM THE INSURANCE COMPANY, THE ENTIRE BALANCE OF THE CLAIMS WILL BE TRANSFERRED TO YOU, WHO WILL THEN BE RESPONSIBLE FOR OBTAINING PAYMENT FROM THE INSURANCE COMPANY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. EVEN IF YOUR INSURANCE PLAN PAYS FOR SERVICES RENDERED UNDER THE TERMS OF OUR CONTRACT WITH THEM, YOU ARE STILL CONTRACTUALLY OBLIGATED TO PAY ALL CO-PAYS, DEDUCTIBLES, MAXIMUM OUT-OF-POCKET EXPENSES, AND CO-INSURANCE, JUST AS WE ARE CONTRACTUALLY OBLIGATED TO COLLECT THEM. ANNUAL OUT-OF-POCKET MAXIMUMS MAY INCLUDE CLAIMS INCURRED AS PART OF THE SERVICES RENDERED BY UHO AND ARE DUE AT THE TIME OF SERVICE UNTIL THE OUT-OF-POCKET MAXIMUM HAS BEEN MET. YOU MAY STILL BE REQUIRED TO MAKE COPAYS FOR EACH VISIT, DEPENDING ON THE TERMS OF YOUR POLICY. CO-INSURANCE IS GENERALLY DUE ONCE THE INSURANCE COMPANY HAS PAID THEIR CONTRACTED PORTION OF THE CLAIM TO UHO, UNLESS YOU HAVE A SECONDARY POLICY, IN WHICH CASE WE WILL FILE THE CLAIM ON YOUR BEHALF IN ACCORDANCE WITH THE PRINCIPLES STATED ABOVE. EVEN IF YOU HAVE BOTH PRIMARY AND SECONDARY COVERAGE, YOU MAY STILL BE RESPONSIBLE FOR
A PORTION OF THE BILL, DEPENDING ON THE AMOUNT PAID BY THE SECONDARY PAYER

CASH DISCOUNTS

If you pay cash for services or treatment, you will be offered a 25% discount from UHO's customary charge for non- drug items.

PAYMENT PLANS

Therapies used in the treatment of cancer and blood disorders are extremely costly. Your physician purchases the drugs used in your treatment in advance. Insurance companies do not pay for all of your health care costs. We can set up a payment plan for you to enable you to discharge your contractual liability under the terms of your coverage. Pay plan installments must be made in addition to co-pays you are obligated to pay at each visit. The payment plan agreement is a binding contract for payment for goods and services provided to you. Pay plans require that you make regular payments as detailed in the agreement. Should you fail to fulfill your obligation under the agreement, you may be sent to a hospital for further treatment, sent to a collection agency, and/or referred to another physician for your care.

PAST DUE ACCOUNTS

Visa, MasterCard and American Express payments are accepted in person, by phone, or by fax. In the event that you do not discharge your financial responsibility, you account may be turned over to a collection agency. If the account is turned over to collections, the person or estate responsible for the account is responsible for all collection costs. Once an account has been placed with an outside collection agency, all payments must be made to that agency. Further, if your account is sent to collections, you may be sent to a hospital for further treatment and/or referred to another physician for your care.

ACCOUNT CONSULTATION

Our physicians and clinical staff do not discuss financial matters. Our billing staff is trained to discuss these matters and will be happy to help you. The primary contact for addressing financial matters is our Patient Advocate. If you still need assistance after consultation with our billing staff, our Administrator may be consulted, as well.

MEDICAL RECORDS

If you require a copy of your medical record, we will provide ONE for you at no charge. We require a written record request and, by statute, have up to 30 days from receipt of the written request to provide the records.

ASSIGNMENT AND RELEASE

I hereby authorize my physician to furnish my insurance company(ies) or their representatives information concerning illness or treatments. I hereby assign the payment of insurance benefits to my physician for medical services and treatments rendered.

I have reviewed and understand Utah Hematology Oncology PC's Patient Financial Policy and agree to abide by its terms.

_____ _____

Signature of patient or responsible person Date

_____ _____

Received by UHO Employee Date

Utah Hematology Oncology
OGDENCLINIC

ARBITRATION AGREEMENT

Article 1 Dispute Resolution By signing this Agreement, we agree to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definitions

A. The term "we", "parties", or "us" means you, the Patient, and the Provider, depending on context.
B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-malpractice claims.
C. The term "Provider" means the physician, group of clinics and their employees, partners, associates, agents, successors, or estates.
D. The term "Patient" or "you" means you and any person who makes a Claim for care given YOU, such as your heirs, spouse, children, parents or legal representatives.

Article 3 Dispute Resolution Options

A. Methods available for Dispute Resolution.
We agree to resolve a Claims by:
1. Working directly with each other to try and find a solution that resolves the Claim; OR
2. Using non-binding mediation (each of us will bear½ of the cost); OR
3. Using binding mediation as described in this Agreement. You

may use any of these methods to resolve your claim.

B. Legal Counsel
Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorneys.

C. Arbitration - Final Resolution If working with the provider using non-binding methods does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice To make a claim under this Agreement, mail a notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail, it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
B. Arbitrators Within 30 days of receiving the notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three (3) arbitrators, unless we agree that a single arbitrator may resolve the Claim.
1. Appointed Arbitrators You will appoint an arbitrator of your choosing and all Provider(s) will appoint an arbitrator of their choosing.
2. Jointly-Selected Arbitrator You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly- Selected Arbitrator"). If you and the Provider cannot agree on a Jointly-Selected Arbitrator, the arbitrators selected by each of the parties will choose a Jointly-Selected arbitrator from a list of individuals approved as arbitrators by the state of federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected arbitrator, either or both of us may request that a Utah court select an individual from the lists above. Each party will pay their own fees and costs in such an action. The Jointly-Selected arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

C. Arbitration Expenses You will pay the fees and costs of the arbitrator you appoint and the Provider will pay the fees and costs of the arbitrator the Provider appoints. Each of us will also pay½ of the fees and expenses of the Jointly- Selected arbitrator and any other expenses of the arbitration panel.
D. Final and Binding Decision A majority of three (3) arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration act.
E. All Claims May be Joined Any person or entity that could appropriately be named in a court proceeding ("Joined Party") is entitled to participate in this arbitration so long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A Joined Party does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement

Article 5 Liability and Damages may be Arbitrated Separately At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly-Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue/ Governing Law The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration act govern this Agreement. We hereby waive the pre litigation and review requirements. The arbitrators will apportion fault to all persons or entities that contributed with the injury claimed by the Patient, whether or not those persons or entities are part of the arbitration.

Article 7 Term/ Rescission/ Termination

A. Term This agreement is binding on both of us for a period of one year unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
B. Rescission You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission notice is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from the Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this Agreement (see article 4(E)).
C. Termination If the agreement has not been rescinded, either party may still terminate it at any time, but termination will not take place until the next anniversary of the signing of the Agreement. To terminate this agreement, send written notice by registered or certified mail to the Provider. This agreement applies to any Claim that arises while it is in effect, even if you file a claim or request arbitration after the Agreement has been terminated.

Article 8 Severability If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration I have received a written explanation of the terms of this agreement. I have the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this agreement instead of having them heard by a judge or jury. I understand the role of arbitrators and the manner in which they are selected. I understand the responsibility for arbitration-related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy
I have received a copy of this document.

Date:_____

PROVIDER	PATIENT
_____	_____
Name of Physician	Name of Patient (print)
By:	
_____	_____
Signature of physician or authorized representative	Signature of patient or patient's representative